



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

MEDME SERVICES CORPORATION  
PO BOX 920173  
EL PASO TX 79902

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

EL PASO ISD

#### **Carrier's Austin Representative Box**

Box Number 17

#### **MFDR Tracking Number**

M4-11-1088-01

#### **MFDR Date Received**

NOVEMBER 29, 2010

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "1. The disputed fees are for specific supplies warranted by the DWC after purchase of the TENS unit and necessitated by the use of the TENS unit. 2. These supplies are Medicare approved and payable as billed. These supplies should be paid as they have been properly distributed to the patient and appropriately billed to the carrier... 3. Under the Medicare fee schedule of the Supplier Manual, Chapter 43.2 reads as follows: "Separate allowance will be made for replacement supplies when they are medically necessary and are used with a TENS/NMES unit that has been purchased and/or approved by Medicare." 4. Partial payments for the specified DOS has been received and additional payment of separate line items have been appealed and denied. These items are necessary. Purchase of the TENS unit was pre-authorized (see attached) thereby warranting additional supplies for continued use and benefit by the patient."

**Amount in Dispute:** \$541.67

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "...The TENS supplies were billed on December 3, 2009, one day after MEDME Services billed for the purchase of the TENS-4 lead unit on December 2, 209 [sic]. Enclosed is a copy of the bill along with the explanation of benefits indicating reimbursement of \$469.56. It is felt the reimbursement for the purchase included the first month's supplies. According to Medicare Local Coverage Determination #L5031 separate allowance is for replacement supplies once the unit has been purchased. Billing for replacement supplies one day after the unit is purchased is not justified. Also, the provider did not comply with the billing requirements. According to LCDL5031 a maximum of two units is to be billed not seven. In regards to procedure code A4557 for lead wires, the Medicare LCD#L5031 states replacement of lead wires more often than every twelve months would rarely be medically necessary. The provider has indicated the lead wires were necessary: 'Because the electrical current flows through these wires it is imperative that they be replaced regularly for the patient's safety.' Since MEDME Services did not provide medical literature substantiating their statement, it is not felt medical necessity has been established for monthly lead wires. Therefore, no allowance is recommended for A4557. In summary, no allowance is recommended for any of the disputed codes."

**Response Submitted by:** Argus Services, 9101 LBJ Freeway, Ste. 600, Dallas, TX 75243

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3, 2009	HCPCS Code A4595-NU	\$264.67	\$ XXXX
April 5, 2010, May 5, 2010, June 7, 2010, July 7, 2010 and September 9, 2010	HCPCS Code A4557-NU	\$27.00	\$0.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of medical treatment/services.
3. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
4. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97G – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. \*Supplies are included in the rental/or purchase.\*
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was process properly.
  - 97H – The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated. \*Service(s)/Procedure is included in the value of another service/procedure billed on same date.

#### **Issues**

1. Did the requestor bill the correct number of units of HCPCS Code A4595-NU in accordance with Medicare requirements?
2. Were some services denied as not medically necessary by the respondent in their position summary?
3. Is the requestor entitled to reimbursement?

#### **Findings**

1. According to the bill submitted by the requestor, the amount of TENS leads billed on December 3, 2009 was 7 units. The requestor states on their table of disputed services: "The unit was purchased. The supplies are included in the rental (DOS) 10/19/2009 but not with the purchase." The requestor billed the TENS unit on December 2, 2009 and then on December 3, 2009 billed 7 units of HCPCS Code A4595. 28 Texas Administrative Code §134.203(a)(5) states that "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. Local Coverage Determination # L5031 states "Separate allowance will be made for replacement supplies when they are medically necessary and are used with a TENS unit that has been purchased and/or approved by Medicare. If 2 TENS leads are medically necessary, then a maximum of one unit of code A4595 would be allowed per month..." The Requestor has not submitted documentation to support the billing of 7 units of HCPCS Code A4595. Therefore, reimbursement is not recommended
2. The requestor billed HCPCS Code A4557-NU on April 5, 2010, May 5, 2010, June 7, 2010, July 7, 2010 and September 9, 2010. The respondent denied the services as 97H – "The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated." The respondent raised medical necessity in their response to the request for medical fee dispute resolution stating "In regards to procedure code A4557 for lead wires, the Medicare LCD#L5031 states replacement of lead wires more

often than every twelve months would rarely be medically necessary. The provider has indicated the lead wires were necessary: 'Because the electrical current flows through these wires it is imperative that they be replaced regularly for the patient's safety.' Since MEDME Services did not provide medical literature substantiating their statement, it is not felt medical necessity has been established for monthly lead wires. Therefore, no allowance is recommended for A4557." Texas Administrative Code §133.307(d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section."

28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

3. Review of the submitted documentation finds that the requestor has not supported their position; as a result reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
February 27, 2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**